MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:
EDS ADJUSTMENT UNIT
PO BOX _____(PAYER SPECIFIC)
RALEIGH, NC 27622

A CORRECTED CLAIM AND THE APPROPRIATE RA MUST BE ATTACHED

EDS USE ONLY

One Step: _____

Provider #:_____ Provider Name:_____

Recipient Name:_____ MID#:_____

SUBMIT A COPY OF THE RA WITH REQUEST

Claim #: | | | | | | | | | | | | | | | | | | | |

Date Of Service:	From:_____/_____/_____	Billed Amount:	Paid Amount:	RA Date:
	To: _____/_____/_____	$_____	$_____	_____/_____/_____

Please check (✓) reason for submitting the adjustment request:

☐ Over Payment ☐ Under Payment ☐ Full Recoupment ☐ Other

Please check (✓) changes or corrections to be made:

☐ Units	☐ Procedure/Diagnosis Code	☐ Billed Amount
☐ Dates of Service	☐ Patient Liability	☐ Further Medical Review
☐ Third Party Liability	☐ Medicare Adjustments (Attach all related Medicare Vouchers)	☐ Other

EDS USE ONLY

Do not write in this block

Please Specify Reason for Adjustment Request:

Signature Of Sender: Date: Phone #:

/ / ( ) -

EDS INTERNAL USE ONLY

Clerk ID#:_____Sent to:_____ Date sent:_____/_____/_____

Reason for review:_____

Reviewed by:_____ Date reviewed:_____/_____/_____

Outcome of review:_____

Date received back in the Adjustment Department: _____/_____/_____

Revised 07/07/03